Spring Branch Independent School District

HEALTH SERVICES

Eligibility Report

Physician's Statement for Administration of Special Health Care Services

Student's Name_____ Grade_____ Age_____ Birthdate_____

Parent/Guardian_____ School_____

It is necessary that special health care services be administered during school hours in order to maintain this child's physical health, support school performance and/or transportation requirements.

Health Service prescribed _____

Condition for which service is prescribed: _____

Frequency_____Duration_____

Method of Administration _____

Equipment Needed _____

Equipment Care Method _____

Special Instructions_____

Possible Reactions_____

I certify that this student is under my continuing care, which includes monitoring his/her continuing need for the services and any needed modifications of the services prescribed above.

_____ _____

Licensed Health Care Provider's Name (Please Print) Licensed Health Care Provider's Signature

_____ _____

Address Telephone Date

I hereby grant permission for the school nurse and/or other school personnel so designated to administer this health service to my child according to the physician's statement given above.

_____ _____

Signature of Parent/Guardian Date

Email address_____

R: 09/21 (ch)